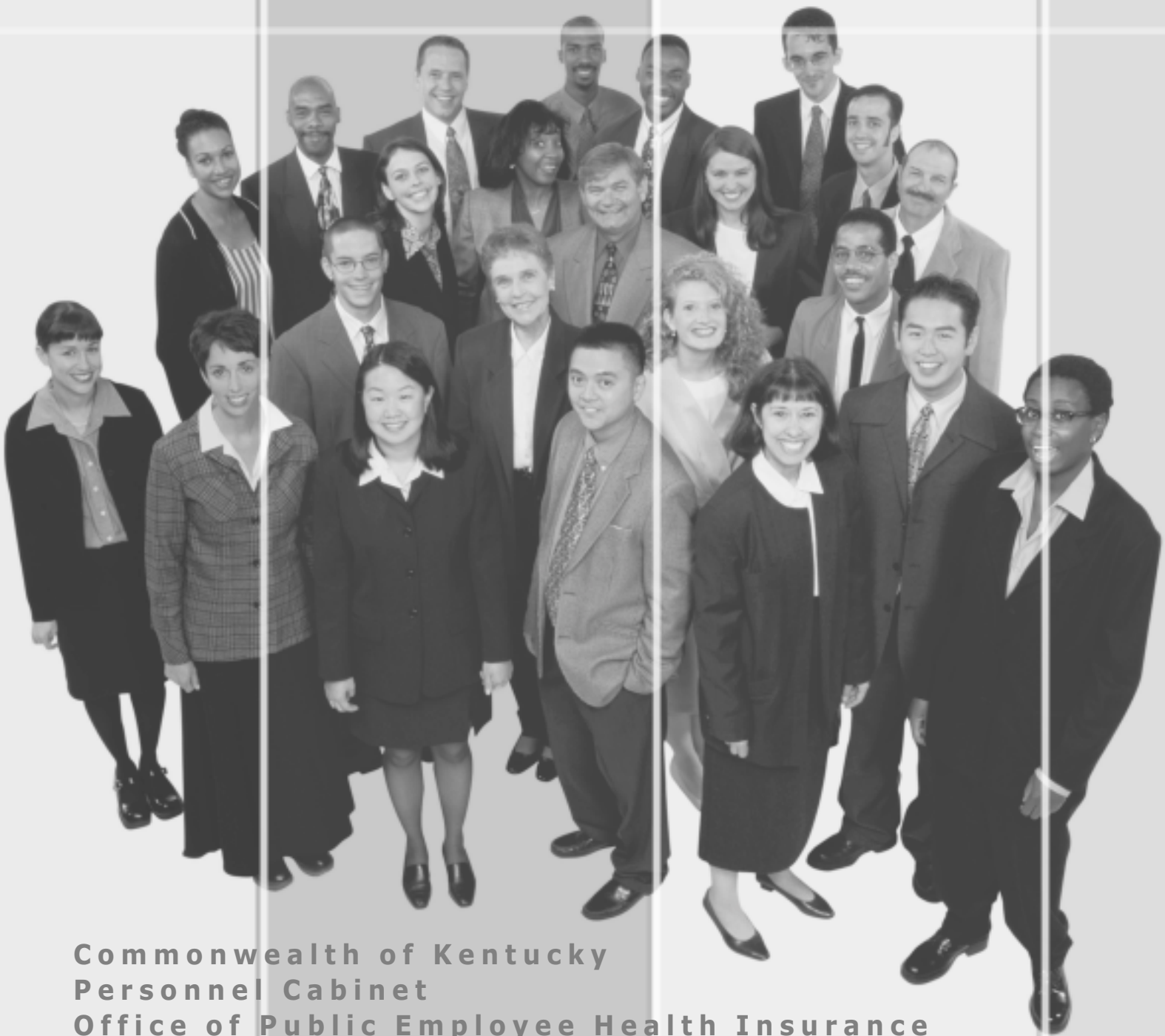
Plan Year 2003

Commonwealth Choice

Flexible Benefits Plan



Commonwealth of Kentucky
Personnel Cabinet
Office of Public Employee Health Insurance
and Fringe Benefits Management Company

Commonwealth of Kentucky

EMPLOYER	DEPARTMENT	HOURS OF OPERATION	PHONE
Commonwealth of Kentucky	Office of Public Employee Health Insurance Member Services Branch Attn: Susan or Mae	M - F 7:30 a.m. - 4:30 p.m. ET	1-888-581-8834 1-502-564-6534

PROVIDER COMPANIES	DEPARTMENT	HOURS OF OPERATION	PHONE/WEB ADDRESS
Fringe Benefits Management Co. (Flexible Spending Accounts)	FBMC Customer Service Interactive Benefits	M - F 7 a.m. - 10 p.m. ET 24 hours a day	1-800-342-8017 1-800-865-3262 www.fbmc-benefits.com

Commonwealth Choice 2003

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Your Enrollment at a Glance

keeping you informed

What's New This Year?

- The Commonwealth of Kentucky contracted with Fringe Benefits Management Company (FBMC) to provide administration of your Flexible Spending Accounts (FSAs).
- FBMC offers valuable FSA enhancements to make using your FSA easier. Direct Deposit, Interactive Benefits, Online Access, and EZ Reimburse® for Rx Card — a card that functions like a debit card to access your Medical Expense FSA funds for prescriptions — are now available for your convenience.
- You may enroll in Direct Deposit to ensure that your FSA reimbursement checks are automatically deposited into your checking or savings account. See Page 7 for more details on Direct Deposit.
- Interactive Benefits provides automated telephone service to help you access your FSA information by phone. See Page 6 for more information.
- You may also visit FBMC's updated Web site to download forms, view your FSA balance and transaction history, and more. See Page 6 for more online access information.
- See Page 12 for regulations regarding Orthodontia processing.

Important Dates to Remember

Your Open Enrollment dates are:
September 16, 2002 - October 4, 2002

Your Period of Coverage dates are:
January 1, 2003 to December 31, 2003

Eligibility Requirements

When does my period of coverage begin?

Current Employees: Your period of coverage is January 1, 2003 to December 31, 2003. See page 17 for changes in status.

New Employees: If you are a new employee, your period of coverage begins on the first day of the second month following your date of hire. If you do not complete a form during this initial eligibility period, you must wait until the next annual Open Enrollment or until you experience a valid Change in Status (see Page 5).

If you enroll during Open Enrollment, your period of coverage is the same as the plan year (January 1, 2003 through December 31, 2003).

Who is eligible to enroll in the Flexible Benefits Plan?

- Active Kentucky State Government employees who are eligible for state-sponsored health insurance coverage.
- Spouses, ex-spouses, children and employees may be eligible for coverage under COBRA law. (See Cobra Q&A on Page 20)

Who are eligible dependents?

Eligible dependents include:

- your legal spouse
- your own unmarried children
- stepchildren and legally adopted children (provided they reside in your household and primarily depend on you for support)
- children for whom you have been appointed legal guardian.

How will retiring affect my eligibility?

According to federal and state law in the case of group health benefits, if you participated in a Medical Expense FSA during the plan year, you can choose to continue your Medical Expense FSA coverage under COBRA if you experience a triggering event under COBRA laws. At the end of the plan year in which the COBRA-qualifying event occurred, however, your Medical Expense FSA coverage will be canceled (See Page 20 for further details).

Appeal Process

If you have an FSA reimbursement claim, or other similar request denied, in full or in part, you have the right to appeal the decision by sending a written request to FBMC for review.

Your appeal must state:

- why you think your request should not have been denied
- the name of your employer
- the date of the services for which your request was denied
- a copy of the denied request
- the denial letter you received
- any additional documents, information or comments you think may have a bearing on your appeal.

PLEASE NOTE: Appeals are approved only if the extenuating circumstances and supporting documentation are within IRS regulations governing the plan.

Change In Status (Qualifying Event)

You may be able to change your current election and make a new election mid-year if you experience an eligible qualifying event. Most qualifying events that allow you to make a change in your Health Insurance may now permit you to make a change in your Medical Expense FSA. Contact your Health Insurance Coordinator or the Office of Public Employee Health Insurance (OPEHI) at 1-888-581-8834.

The IRS requires your enrollment in Commonwealth Choice to continue for the entire plan year, which is January 1, through December 31. However you can modify your contributions to the **Dependent Care Spending Account** if you experience a valid Family Status Change: e.g., marriage; divorce; dependent's birth, death, adoption, or ineligibility; spouse's change in employement; employee's termination of employment, unpaid leave of absence or other related change.

If you experience a Family Status Change, you MUST complete a Family Status Change Form and return it — along with documentation to your Insurance Coordinator **within 30 days** of the change. The Office of Public Employee Health Insurance will review your Family Status Change.

IMPORTANT: Mid-year election changes may be made to the Medical Expense FSA for most qualifying events that allow you to make a change in your Health Insurance. If you experience one of these events, you may be allowed to make a change in the amount of contribution (employer and/or participant) to your account.

Changes After Open Enrollment

Some qualifying events may allow you to increase or decrease the amount in your flexible spending account.

Qualifying events do not allow you to waive coverage outside open enrollment (with five exceptions)

- New Hire
- Marraige
- Spouse obtains employment or employer offers coverage for the first time
- Employee becomes eligible for Medicare (TEFRA)
- Spouse has different open enrollment.

How to Get More Information

using your resources

Welcome to Interactive Benefits

FBMC's 24-hour automated phone system allows you to access your benefits any time to check on a claim, verify the status of a Flexible Spending Account, request a form and more! Getting connected to your benefits is easy. Call the Information Line at: **1-800-865-FBMC (3262).**

Your answers are just a phone call away!

The Interactive Benefits System includes a customer service line called the Information Line. When you dial 1-800-865-FBMC (3262) you will receive step-by-step instructions to access information on your benefits administered by FBMC. The system is designed to provide information on your FSA. For information concerning mid-plan year election changes contact the Office of Public Employee Heath Insurance, Member Services Branch.

Getting Started

All you need is your Social Security Number (SSN) to access the system for the first time. The last four digits of your SSN will be your first PIN (Personal Identification Number). The system will then ask you to select your own confidential 4-digit PIN for future use. Your new PIN cannot be the last four digits of your SSN. If you forget your PIN, you may press zero and a Customer Service Representative will be happy to assist you.

Once you've selected a PIN, the system will give you the following list of options and guide you through a simple, step-by-step process to obtain the information you need. Your PIN is also used to access information on our Web site.

Online Access

Your benefits are only a click away. Visit www.fbmc-benefits.com for up-to-the-minute information about your benefits this plan year. Select "Account Information" from the menu at the top of your screen. Then, enter your employee identification number (your Social Security number) and your PIN. You may also download forms, e-mail our customer service department, and view frequently asked questions about enrollment information and your benefits.

MAIN MENU OPTIONS:

Press 1 for Flexible Spending Accounts
- Current or previous plan year
- Dependent Care or Medical Expense FSA
- Status of last reimbursement request
- Last deposit or payment
- Request a reimbursement form
- Inquire about another FSA

Press 2 for form requests
- Claim forms
- Change In Status/Election Forms

Press 3 for current benefits
Press 4 to change PIN
Press 5 to verify address

Other Options:

Press 0 to transfer to a Customer Service Representative
Press 9 to return to Main Menu
Press * to repeat the menu
Press # to exit Information Line

Important Numbers

Interactive Benefits Information Line:
1-800-865-FBMC (3262)

Fringe Benefits Management Company
Customer Service: **1-800-342-8017**

Fringe Benefits Management Company
Customer Service: **1-800-955-8771 (TDD)**
Monday through Friday, 7 a.m. to 10 p.m. ET.

OPEHI
Member Services Branch: **1-888-581-8834** or **1-502-564-6534**

Important Web Addresses

Fringe Benefits Management Company
Customer Service E-mail Address:
webcustomerservice@fbmc-benefits.com

Fringe Benefits Management Company Web Site:
www.fbmc-benefits.com

Flexible Spending Accounts

What is a Flexible Spending Account?

A Flexible Spending Account (FSA) is an IRS-approved, tax-free account that saves you money on eligible medical and dependent care expenses. You authorize per-pay-period deposits to your FSA from your before-tax salary. Then, as you incur eligible expenses, you request tax-free withdrawals from your account to reimburse yourself. There are two kinds of FSAs: a Medical Expense FSA and a Dependent Care FSA. If you incur both types of expenses, you can establish both accounts.

Why would I enroll in an FSA? To Save Money!

Over a year's time you will probably spend a part of your salary on health or dependent care. You can save money by putting that amount directly into a Flexible Spending Account.

Get the facts about FSAs

If you have questions, call Fringe Benefits Customer Service (Monday-Friday, 7 a.m.-10 p.m. ET) at 1-800-342-8017. You may also e-mail Customer Service at webcustomerservice@fbmc-benefits.com.

Receiving Reimbursement

You should receive your reimbursement within 5-10 days from the time you mail your properly completed reimbursement request. To avoid delays, follow instructions for submitting your requests in the FSA sections to follow.

Direct Deposit

Enroll in Direct Deposit to ensure that your FSA reimbursement checks are automatically deposited into your checking or savings account. There is no fee for this service, and you don't have to wait for postal service delivery of your reimbursement (however, you will receive notification that the claim has been processed). To apply, complete the application form available from your Insurance Coordinator, or by calling FBMC Customer Service at 1-800-342-8017.

FSA Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA.
2. You cannot transfer money between FSAs or pay a dependent care expense from your Medical Expense FSA or vice versa.
3. You have a 90-day grace period (until March 31, 2004) at the end of the plan year for reimbursement of eligible FSA expenses incurred during your period of coverage within the 2003 Plan Year.
4. You may not receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
5. You cannot deduct reimbursed expenses for income tax purposes.
6. You may not be reimbursed for a service which you have not yet received.
7. Be conservative when estimating your medical and/or dependent care expenses for the 2003 Plan Year. IRS regulations state that any unused funds which remain in an FSA account after a plan year ends and all reimbursable requests have been submitted and processed cannot be returned to you nor carried forward to the next plan year.

My Personal Contribution

Without an FSA: (Example)*

$50.00	monthly budget for a medical expense
- 14.33	taxes on that $50 taken from your paycheck
$35.67	amount you have left for medical expense

With an FSA: (Example)

$50.00	monthly FSA deposit for a medical expense
- 0.00	no taxes (no taxes on FSA deposits)
$50.00	amount you have left for medical expense

*Based upon a 22.65% tax rate (15% federal, 6% state, and 7.65% Social Security).

Because the money you deposit (redirect from your salary) in your Medical and Dependent Care FSA is deducted before taxes, the income you use for these expenses is ALWAYS TAX FREE.

Any eligible co-pays or uninsured out-of-pocket expenses may be reimbursed through your Medical Expense FSA. See Page 11 for a partial list of eligible expenses or call FBMC Customer Service at 1-800-342-8017.

Your FSA Contributions Termination or Leave

MEDICAL EXPENSE FSAs

If you experience an event permitting a mid-plan year FSA election change such as termination of employment or unpaid leave, you can continue to contribute to your Medical Expense FSA on an after-tax basis by calling your insurance coordinator within 30 days of the event to apply for continuation of your Medical Expense FSA through COBRA.

As long as you make full after-tax contributions to your Medical Expense FSA, you can receive reimbursements on eligible healthcare expenses incurred during your period of coverage, which is January 1, 2003 through December 31, 2003.

You have a 90-day grace period after the plan year ends (until March 31, 2004) to submit claims for reimbursement of eligible FSA expenses that you incurred during the plan year. Your Medical Expense FSA coverage will not be continued beyond the plan year in which the COBRA qualifying event occurred.

The Family and Medical Leave Act (FMLA) may affect your rights to continue coverage when on leave. For further information, contact your employer.

DEPENDENT CARE FSAs

You cannot continue contributing to your Dependent Care FSA. You can, however, continue to request reimbursement for eligible expenses until you exhaust your account balance or the plan year ends, based on the contributions you made while you were employed or actively employed. The expense must be incurred prior to your termination date.

Is mileage for doctor visits reimbursable?

Yes, it is reimbursable, as long as a receipt, statement or bill is sent along with your request that validates your visit.

Expenses incurred for transportation are not considered a dependent care expense.

How do you submit mileage for reimbursement ?

Calculate the mileage on the actual bill/receipt detailing the following: roundtrip mileage multiplied by $0.13 (which is the IRS current amount per mile reimbursable) along with the name of the provider visited.

Example: If your office visit with Dr. Jay on 1/1/03 resulted in a total of 80 miles roundtrip, your note should read: 1/1/03—80 miles x .13= $10.40 for Dr. Jay.

On your claim form indicate "Mileage" under Provider of services with the dates of travel and $10.40 as your amount requested for reimbursement. In addition, attach your statement, bill or receipt along with your request that validates your visit.

Are all doctors visits reimbursable?

If the service provided is reimbursable for vision, dental or medical under IRS regulations, then travel to and from the healthcare office to obtain service is reimbursable.

Are parking fees and tolls to the doctor's office reimbursable?

Yes, in addition to mileage reimbursement at $0.13 per mile, you may seek reimbursement for parking fees and tolls to your medical appointment. To substantiate the claim you will need to provide a receipt for the toll and/or parking fee in addition to a bill or receipt from your healthcare provider.

Is mileage reimbursable for visits to and from my local pharmacy for my prescription(s)?

Yes, a visit to your pharmacy will be treated as a visit to your local healthcare provider.

Are expenses incurred for out-of-town healthcare services reimbursable,i.e., airline fare, hotel room and rental car?

You may include the medical expense amounts you pay for transportation to another city if the trip is primarily for, and essential to, receiving medical services. You cannot include in medical expenses a trip or vacation taken merely for a change in environment, improvement of morale, or a general improvement of health, even if you make a trip on the advice of a doctor.

(IRS Publication 502, Page 12).

Are the lodging expenses I incur during my dependent's out-of-town hospitalization reimbursable?

Yes. You may be able to include in medical expenses the cost of lodging not provided in a hospital or similar institution. The amount you include in medical expenses for lodging cannot be more than $50 per night for each person. Lodging is included for a person for whom transportation expenses are a medical expense because that person is traveling with the dependent receiving medical care. For example, if a parent is traveling with a sick child, up to $100 per night can be included as a medical expense for lodging. Meals are not included. (IRS Publication 502, Page 8.)

EZ REIMBURSE® for Rx

The EZ REIMBURSE® for Rx card electronically debits funds from your Medical FSA account when an eligible, uninsured prescription drug expense is incurred.*

Much like other debit cards, there is no risk of overspending. If funds are not available, the transaction is denied. Because no credit is being extended, cards are available to anyone who signs up for a Medical Expense Flexible Spending Account.

About 50 percent of all FSA medical claims are for prescription drugs. FBMC and its partners developed a system enabling online, real-time, adjudication of prescription drug claims. When you present the card at participating pharmacies to buy a prescription drug or to pay the prescription co-pay, your FSA account is automatically debited. There are no claim forms or receipts to send. You also avoid the double-hit to your wallet while waiting for reimbursement.

How do I get an EZ REIMBURSE® for Rx Card?

When you sign up for a MFSA, you will automatically receive your EZ REIMBURSE® for Rx Card in the mail, unless you elect to waive the card by indicating so on your enrollment form. It comes to you just like a regular credit card; you call the toll-free number on the back to activate the card. For additional information regarding the EZ REIMBURSE® for Rx card, call FBMC Customer Service at 1-800-342-8017, Monday through Friday, 7 a.m. - 10 p.m. ET.

What does it cost to use the EZ REIMBURSE® for Rx Card?

Unless you elect to opt out of the EZ Reimburse Rx card, there is a $6 non-reimbursable annual fee. This fee is deducted from your MFSA at the beginning of the plan year. In addition, there is a $0.50 fee for each transaction; Therefore, when you budget for your FSA deductions, you may want to consider the fee in your calculations. Each prescription counts as one transaction. For example, if you fill two prescriptions in one visit to the pharmacist, you will be assessed $1.00 in transaction fees — one $0.50 transaction fee per prescription.

When do I use paper claim forms?

If a merchant or vendor is not a participating pharmacy, you must use an alternate method of payment and submit a paper claim. You will need to file a claim form, attach your receipts and wait for the reimbursement. To shorten the wait, you can apply for direct deposit and speed up your reimbursement.

EZ REIMBURSE® for Rx Advantages:

- Instant reimbursements – cash-free transactions!
- Paperless prescription purchases – instant claims adjudication
- You save taxes by participating in an MFSA account

***Please see the Beyond Your Benefits section of this book for information about debit card reimbursement.**

Medical Expense FSA

your money at work for you

Minimum Deposit per paycheck: $5
Maximum Deposit per paycheck: $120

Who is eligible?

Under the Medical Expense FSA, you may be reimbursed for eligible expenses incurred by the following:

- yourself
- your spouse and
- your dependents. To qualify as a dependent, an individual must meet the following criteria:
  a) the individual must be your relative or live with you for at least one calendar year
  b) he or she must be a U.S. citizen or a resident of the U.S., Mexico or Canada and
  c) you must have provided the individual with at least half of their total support and/or expenses during the past calendar year.

An eligible child of divorced parents is treated as a dependent of both parents. Therefore, either or both parents can establish a Medical Expense FSA.

Availability

Once you sign up for a Medical Expense FSA and decide how much to contribute, the maximum annual amount elected by you, for reimbursement of eligible uninsured, out-of-pocket medical expenses, will be available throughout your period of coverage (reduced for prior reimbursements made during the same period of coverage), provided the request does not exceed your annualized contribution.

It's like a cash advance because you don't have to wait for the cash to accumulate in your account before you can use it to pay for your uninsured, eligible medical expenses. Your money is tax-free and interest free!

FSA vs. Claiming Expenses on IRS Form 1040

Unless your itemized medical expenses exceed 7.5 percent of your adjusted gross income, you can't get a break by claiming them on your IRS Form 1040.* But you can save taxes by paying for your uninsured, out-of-pocket medical expenses through a tax-free Medical Expense FSA.

For instance, if your adjusted gross income is $25,000, the IRS would only allow you to deduct itemized expenses that exceed $1,875 or 7.5 percent of your adjusted gross income. But, if you have $2,000 in eligible medical expenses, the FSA saves you $813 on your medical expenses in federal income (27 percent), state (6 percent) and Social Security taxes (7.65 percent).

With a Medical Expense FSA, the money you set aside for medical expenses is deducted from your salary before taxes. So, it is ALWAYS tax-free, regardless of the amount. By enrolling in a Medical Expense FSA, you guarantee your savings.

***Note:** Both you and your spouse's incomes must be included for the purposes of determining adjusted gross income.

Ineligible Expenses

- Insurance premiums
- Vision warranties and service contracts
- Most over-the-counter drugs and medical supplies (even if prescribed by your healthcare provider)
- Health or fitness club membership fees
- Cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition

Benefit Tips

If you are thinking of putting money into a Medical Expense FSA to pay for a planned surgical procedure, please verify with your healthcare provider (prior to the start of the upcoming plan year) that you are a suitable candidate for the procedure before committing the money to your FSA.

Eligible Expenses

Acupuncture*
Alcoholism treatment
Ambulance service
Artificial limbs
Artificial teeth
Birth control pills
Braille books & magazines for use by person with visual impairment
Car controls for use by a person with a disability
Chiropractic care
Co-insurance for health insurance
Contact lenses, saline solution, and enzyme cleaner*
Co-payments
Crutches, amount paid to buy or rent
Deductibles for health insurance
Dental fees*, includes X-rays, fillings, braces, extractions, dentures, etc.
Dental implants
Diagnostic tests
Doctors' fees
Duplicate prosthetic devices***
Drug addition treatment at a therapeutic center for drug addiction
Experimental medical treatment
Eyeglasses and eye examinations***
Guide dogs/trained animals used to assist persons with a physical disability
Hearing aids, batteries to operate them, and hearing exams
Hospital services
Injections
In-patient therapy for mental or nervous disorders
In vitro fertilization*
Lab fees that are part of your medical care
Laser eye surgery (RK, PRK, Lasik)****
Learning disability tuition for a child who has severe learning disabilities*
Nursing services*
Operations****
Optometrist fees
Orthodontic treatment*
Orthopedic shoes*
Oxygen
Peridontal fees
Prescription drugs**
Psychoanalysis
Psychologist fees
Radial keratotomy****
Smoking cessation drugs/programs
Special schools for individuals with disabilities*
Sterilization****
Surgery****
TDD phone for individuals who are deaf or hearing impaired
Therapy*
Transplants
Transportation for local medical care
Vitamins prescribed by a doctor
Vaccinations
Wheelchairs
X-rays

* To be eligible for reimbursement, some treatments, prescription drugs or services may require written proof of medical necessity, or other additional documentation from your healthcare provider.

** Not all drugs requiring a prescription are approved by the IRS as eligible for reimbursement.

*** The effective date for glasses and prosthetic devices is the day the item is available to be picked up, not the date ordered.

**** Unused funds designated for Medical Expense FSAs cannot be refunded to you. Please verify with your healthcare provider (prior to the commencement of the upcoming plan year) that you are a suitable candidate for any surgical procedure before committing the money to your FSA.

Setting Aside Funds

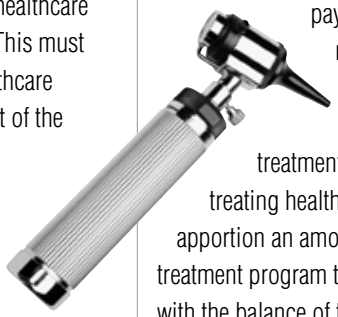
Written Confirmation From a Healthcare Provider is Recommended. Before setting aside money in a Medical Expense FSA for any surgical procedure (i.e. corrective laser eye surgery) to treat, cure or mitigate a specific medical condition, it is recommended that you complete all testing procedures and secure written approval as required by the healthcare provider performing your surgery. This must be obtained from your surgical healthcare provider prior to the commencement of the plan year in which the procedure is scheduled and performed. A change in your health circumstances that makes you an unsuitable candidate for a surgical procedure after the 2003 Plan Year commences will not permit you to reduce or cancel your Medical Expense FSA.

Weight-loss Programs and the IRS

It is significant to note that the IRS officially recognizes obesity as a disease and out of pocket medical expenses for doctor prescribed treatment of obesity as reimburseable under your Medical Expense FSA. This includes treatment in weight-loss programs and/or meetings; it excludes diet foods that are substitutes for normal nutritional requirements.

Extended (Non-Cosmetic) Medical Treatments, Including Orthodontia

IRS regulations provide that advance reimbursement of the **entire** cost for any extended (non-cosmetic) medical treatment program, including orthodontia services, cannot occur if the services reflected in such payment have not been received. However, a reasonable down payment at the commencement of a treatment program is permitted if the treating health care provider is able to apportion an amount of the entire cost of the treatment program to specific initial services with the balance of the cost of the treatment program apportioned over the remaining months of the treatment as services are received. ***Only*** *in the case of extended orthodontia treatment* will services be considered rendered monthly (whether or not an office visit occurs during the month), when you submit copies of monthly statements or payment coupons, as proof of continuing service.



How to Request Reimbursement

To request reimbursement from your Medical Expense FSA, you must mail or fax a correctly completed FSA Reimbursement Request Form along with one of the following:

- a receipt, invoice or bill from your healthcare provider listing the date you received the service, the cost of the service, the type of service and the person for whom the service was provided, or
- an Explanation of Benefits (EOB) from your health insurance provider that shows the type of service you received, the date and cost of the service, and any uninsured portion of the cost, or
- a written statement from your healthcare provider that the service was medically necessary if those services *could* be deemed cosmetic in nature.

Mail to: Contract Administrator
Fringe Benefits Management Co.
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax to: 850-425-4608

Dependent Care FSA

a tax break just for caring

Minimum Deposit per Paycheck: $5
Maximum Annual Deposit: The maximum contribution depends on your tax filing status as the list below indicates.

Tax Filing Status:

- If you are married and filing separately, your maximum is $2,500
- If you are single and head of household, your maximum is $5,000
- If you are married and filing jointly, your maximum is $5,000
- If either you or your spouse earn less than $5,000 a year, your maximum is equal to the lower of the two incomes
- If your spouse is a full-time student or incapable of self-care, your maximum is $3,000 per year for one dependent and $5,000 per year for two or more dependents

How the Dependent Care Flexible Spending Account Could Work for You:

A Dependent Care FSA can help recover some of the money you spend to ensure your dependents (child, adult or elder) are taken care of while you're working.

Who is Eligible?

Under the Dependent Care FSA, you may be reimbursed for eligible care expenses incurred by the following:

- Children 12 years or younger who reside in your household
- Adults/children mentally or physically incapable of self-care who spend at least eight hours a day in your household

FSA vs. Child Care Tax Credit

Generally an FSA saves you more in taxes than the Child Care Tax Credit, but it depends on your income. If you expect your adjusted gross family income to exceed approximately $40,000 and you are not in the 15 percent federal tax bracket, the Dependent Care FSA will probably benefit you more.

You can use the Dependent Care FSA and file for a tax credit as long as the total for both (the amount you have placed in your FSA plus the amount you have paid for dependent care) does not exceed the tax credit limits; $3,000 for one dependent and $6,000 for two or more dependents. You cannot use the tax credit if you are married and filing separately, and you cannot take a credit for expenses that have been reimbursed through your FSA. Call FBMC Customer Service at 1-800-342-8017 for assistance in determining the best choice for you. You may also e-mail FBMC Customer Service at webcustomerservice@fbmc-benefits.com.

NOTE: The **new** definition of "earned income" includes wages, salaries, tips and other employee compensation, but only if such amounts are includible in gross income for the taxable year.

Eligible Expenses

Generally, child, adult and elder care costs that allow you and your spouse to work or actively look for work are eligible for reimbursement. If you are married, your spouse must work, be a full-time student or be mentally or physically incapable of self-care. Payments for dependent care services provided by your dependent, your spouse's dependent, or your child who is under age 19 are not eligible for reimbursement.

Examples:

- Day care facility fees for qualified dependents
- Local day camp fees for qualified dependents
- Baby-sitting fees for at-home care of qualified dependents while you and your spouse are working (care cannot be provided by you, your spouse, or other dependent)

Ineligible Expenses:

- Child support payments or child care if you are a non-custodial parent
- Payments for dependent care services provided by your dependent, your spouse's dependent, or your child who is under age 19
- Healthcare costs or educational tuition
- Overnight care for your dependents (unless it allows you and your spouse to work during that time)
- Nursing home fees
- Diaper services
- Books and supplies
- Activity fees
- Kindergarten expenses

How to Request Reimbursement

Each Dependent Care FSA reimbursement request sent by mail or fax must include a properly completed FSA Reimbursement Request Form, including receipts for payment showing the following:

- the date your dependent received the care (for example, February 10, 2003 through February 14, 2003) not the date you paid for the service
- the name, address and tax identification number of the facility or
- the name, address, Social Security number and signature of the individual providing the dependent care service.

Be certain you can obtain the above information before you enroll in a Dependent Care FSA. This information is required with each request for reimbursement.

Mail to: Contract Administrator
Fringe Benefits Management Co.
P.O. Box 1800
Tallahassee, FL 32302-1800
Fax to: 850-425-4608

Note: If you elect to participate in the Dependent Care FSA, or if you file for the Child Care Tax Credit, you must attach IRS Form 2441, which reflects the above information, to your 1040 income tax return. Failure to do this could result in the IRS not allowing your pre-tax exclusion.

When to Request Reimbursement

You can request reimbursement as often as you like; however, your request cannot be approved for payment unless the last date of service for which you are requesting reimbursement has passed.

For example, if you pay your dependent care provider on February 1 for the entire month of February, you can submit your reimbursement request for all of February only after the last day of care for that month has been received.

If your dependent care provider requires you to pay in advance for a period of time not to exceed one month in advance (e.g., at the beginning of the month for care throughout the month), FBMC will authorize your request for reimbursement as often as you want to submit it—weekly, biweekly or monthly.

Make sure that your FSA Reimbursement Request Form identifies the dates for which service has already been received and the amount you are requesting reimbursed. Make several copies of your original receipt, so that photocopies of it can be attached to each request.

For timely processing of your reimbursement, your payroll contributions must be current.

Availability

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depends on the actual amount in your account. Unlike a Medical Expense FSA, the entire maximum annual amount is not available at the beginning of the plan year.

Benefit Tips

Be certain you can obtain the information needed to request reimbursement before you enroll in a Dependent Care FSA.

A properly completed request will help speed along the process of your reimbursement, allowing you to receive your check or Direct Deposit promptly.

FSA Worksheets

Deciding How Much to Deposit

To figure out how much to deposit in your FSA, refer to the following worksheets. Calculate the amount you expect to pay during the plan and calendar years for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount cannot exceed the established IRS calender year or your employer's plan year limits. (Refer to the individual FSA descriptions in this booklet for limits.) **Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.**

TAX-FREE MEDICAL EXPENSE WORKSHEET

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year, which is January 1, 2003 though December 31, 2003.

YOUR UNINSURED MEDICAL, DENTAL AND VISION EXPENSES

_____ $_____

_____ $_____

_____ $_____

_____ $_____

_____ $_____

SUBTOTAL

Estimated eligible uninsured medical expenses for your period of coverage during the plan year.** Amount cannot exceed $120 per paycheck $ _____

DIVIDE

by the number of paychecks with deductions you will receive during the plan year (24).* _____

This is your pay period contribution* $ _____

*If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

**Remember to inlcude the $6.00 non-reimbursable annual fee as well as $0.50 transaction fees for each transaction, when calculating your Medical Expenses.

TAX-FREE DEPENDENT CARE WORKSHEET

Estimate your eligible dependent care expenses for the plan year, which is January 1, 2003 through December 31, 2003.

NUMBER OF WEEKS _____

you will have dependent (child, adult or elder) care expenses from January 1, 2003 through December 31, 2003. *Remember to subtract holidays, vacations and other times you may not be paying for eligible child, adult or elder care.*

MULTIPLY _____

by the amount of money you expect to spend each week

SUBTOTAL

Remember, your total contribution cannot exceed IRS limits for the calendar year and your employer's plan year. $ _____

DIVIDE

by the number of paychecks with deductions you will receive during the plan year (24).* _____

This is your pay period contribution* $ _____

*If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

At your request, your FSA reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit.

Employer Contribution

You may be eligible for an Employer Contribution toward the **Medical Flexible Spending Account** if the monthly cost of the health insurance plan you choose is less than $234.00. ***Note: the Dependent Care Account is not eligible for an employer contribution.***

Use the worksheet below to determine if you qualify. The following three (3) requirements must also be met:

- You must be an active Kentucky State Government employee who is eligible for state-sponsored health insurance coverage.
- Your health plan must total less than $234 per month **or** you may waive coverage and deposit up to $2,808 of state contributions into your account for the year.
  Note: If you elect to waive you health insurance, you must fill out sections I and V of the health insurance application. You must complete both the health insurance application and the Commonwealth Choice application and turn them in to your Insurance Coordinator.
- You must **elect to participate** in the Flexible Spending Account Program **by completing the enrollment form** found in this booklet. Enrollment is NOT automatic. Your participation will **not** "roll over" from one year to the next. If you wish to participate, complete your enrollment form now.

Monthly Employer Contribution for Health Insurance for 2003	1.	$234.00
Enter the monthly premium for the health insurance plan you have selected (If you have waived coverage, enter -0- on line 2)	2.	_____
Subtract line 2 from line 1 This is your eligible monthly employer contribution toward the Medical Flexible Spending account.*	3.	_____

Divide this number by 2 and enter on line "a" of the enrollment form. Round down if the number is uneven.

* If line 2 is larger than line 1, you do not qualify for the Employer Contribution, and the difference will be deducted from your paycheck to cover your insurance premium.

Changing Your Coverage

Am I permitted to make mid-plan year election changes?

Under some circumstances your employer's plans and the IRS may permit you to make a mid-year election change or vary a salary reduction amount depending on the type of pre-tax coverage and the triggering event.

How do I make a change?

You can change your Flexible Spending Account (FSA) election(s), or vary the salary reduction amounts you have selected during the plan year, only under *limited* circumstances as provided by your employer's plan(s) and established IRS guidelines. A partial list of permitted, and not permitted events under your employer's plan(s) appear on the following page. *Election changes must be consistent with the event.*

To Make a Change: Within **30 days** of an event that is consistent with one of the events on the following page, you must complete and timely submit a Change in Status/Election Form. Contact your insurance coordinator to obtain this form. Documentation supporting your election change request is required. Upon the approval and completion of processing your election change request, your existing FSA(s) elections will be stopped or modified (as appropriate). Generally, mid-plan year pre-tax election changes can only be made prospectively, no earlier than the first payroll after your election change request has been received by your insurance coordinator, unless otherwise provided by law. If your FSA election change request is denied, you will have **30 days**, from the date you receive the denial, to file an appeal with your insurance coordinator. For more information, refer to the *Appeals Process* section on Page 4.

Changing Your Coverage continued

What are the IRS Special Consistency Rules governing Changes in Status?

1. *Loss of Dependent Eligibility*. If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility requirements for coverage due to: your divorce, or annulment from your spouse; your spouse's or dependent's death; or a dependent ceasing to satisfy eligibility requirements, you may elect to decrease or cancel the accident or health insurance coverage only for the individual(s) involved. You cannot decrease or cancel any other individual's coverage under these circumstances.
2. *Gain of Coverage Eligibility Under Another Employer's Plan*. For a change in which you, your spouse, or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may elect to cease or decrease coverage only for that individual if coverage for that individual becomes effective or is increased under the other employer's plan.
3. *Dependent Care Expenses*. For dependent care expenses, you may change or terminate your Dependent Care FSA (DFSA) election only if: (i) such change or termination is made on account of and corresponds with a Change in Status (CIS) that affects eligibility for coverage under your employer's or other employer's plan; or (ii) the election change is on account of and corresponds with a CIS that affects eligibility of dependent care expenses for the tax exclusion available under IRC § 129.
4. *Group-term Life Insurance, Dismemberment or Disability Coverage*. For any valid CIS event, you may elect either to increase or decrease these types of coverage.

Changes in Status:	
Marital Status	A change in marital status including marriage, death of a spouse, divorce or annulment (legal separation is not recognized in all states).
Change in Number of Tax Dependents	A change in number of dependents, including the following: birth, death, adoption, and placement for adoption. Existing dependents can also be added whenever a dependent gains eligibility as a result of a valid CIS event. IRS special consistency rules 1 and 4 may apply as noted below.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee that affects the individual's eligibility under an employer's plan; such as commencement or termination of employment
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan such as: due to attainment of legal age; student status; marital status; employment status.
Change in Residence	A change in the place of residence of the employee, spouse, or dependent that affects eligibility to be covered under an employer's plan; such as moving out of an HMO service area (except for Medical Expense FSAs).

Some Other Permitted Changes:	
Coverage and Cost Changes	Your employer's plans may permit election changes due to cost or coverage changes that affect other pre-tax benefits, excluding a Medical Expense FSA. Contact your employer. You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Open Enrollment Under Other Employer's Plan	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if*: • they participate in their employer's plan, and • their employer's plan permits mid-plan year election changes under this event. *Does not apply to a Medical Expense FSA.
Judgement/Decree/Order	If a judgement, decree, or Order from a divorce, legal separation (if recognized by state law), annulment, or change in legal custody requires that you provide *accident or health coverage* for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the Order requires that another individual (including your spouse and former spouse) cover the dependent child and provide coverage under that individual's plan, you may change your election to *revoke* coverage only for that dependent *child and only if the other individual actually provides the coverage.*
Medicare/Medicaid	Gain or loss of Medicare/Medicaid eligibility and enrollment may trigger a permitted election change.
FMLA Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.
HIPAA	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC Sec. 125 cafeteria plan may permit you to change a salary reduction election, to pay for the extra cost for group health coverage, on a **pre-tax** basis, efffective *retroactive* to the date of the CIS event, **if you enroll your new dependent within 30 days** of one of the following CIS events: *birth, adoption, or placement for adoption.* Note that a health "Medical Expense" FSA is **not** subject to HIPAA's special enrollment provisions if it is funded **solely** by employee contributions.

COBRA Q&A

What is the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)?

According to federal and state law, if you are a covered employee who has lost group health plan coverage due to a triggering event, you and your covered dependents are entitled to continue your Medical Expense FSA coverage in effect at the time of the event. Contact your insurance coordinator for continuation of your Medical Expense FSA within **30 days** of a COBRA qualifying event.

What are COBRA Qualifying Events?

As a general rule, there is a COBRA "qualifying event" if:

- a covered employee's termination of employment occurs other than due to gross misconduct. This includes retirement.
- there is a reduction in a covered employee's hours of employment.
- a covered employee dies.
- a covered employee's becoming entitled to Medicare.
- a covered employee experiences a divorce or legal separation.
- a child ceases to qualify as a dependent under the terms of the plan.

How does HIPAA affect COBRA?

HIPAA gives a person already on COBRA specific enrollment provisions to add dependents only if such a person:

- acquires a new dependent, or
- if an eligible dependent declines coverage because of alternative coverage and
- later loses such coverage due to certain qualifying reasons.

Spouse or dependents who are added under this paragraph do not become Qualified Beneficiaries and their coverage will end at the same time coverage ends for the person who elected COBRA and later added them.

How are COBRA Qualified Beneficiaries affected?

Except for your employer's Medical Expense FSA Plan, the same open enrollment rights are extended to COBRA qualified beneficiaries as are available to active employees.

How long is the COBRA coverage period?

A qualified beneficiary's maximum coverage period is determined by the qualifying COBRA event and extends for the rest of the plan year in which the qualifying event occurs. Until the maximum COBRA period expires, the qualified beneficiary may re-enroll for subsequent plan years during annual open enrollment and elect a higher or lower annual coverage limit than before.

How does COBRA affect my Medical Expense FSA Plan?

In accordance with COBRA, your employer's plan offers limited COBRA continuation rights to qualified beneficiaries who have under spent their MFSA accounts as of the date of the COBRA qualifying event. Unless otherwise elected, the spouse and dependents of the person electing COBRA will be covered. Only qualified beneficiaries have election rights and may elect separate COBRA coverage with:

- a separate Medical Expense FSA at the elected annual limit in effect at the time of the COBRA qualifying event and
- a separate COBRA premium through the end of the plan year in which the COBRA qualifying event occurs.

Who are Qualified Beneficiaries?

- the person must be a covered employee, the spouse of a covered employee, or the dependent child of a covered employee; and
- the person must be covered by a group health plan immediately before the qualifying event occurs.

How do I pay for continuation of coverage?

The monthly COBRA premium for coverage is the monthly premium you were paying *via* salary reductions before the date of the COBRA qualifying event, and must be received by Susan by the first of the month. Under COBRA, your premium must be paid by check or by money order. Administration fees apply.

When must I make my initial COBRA elections?

A qualified beneficiary must elect COBRA coverage 60 days after:

- the employee's loss of group health plan coverage or
- the date the Election Notice was mailed to the qualified beneficiary.

If a qualified beneficiary fails to meet this deadline, he or she will be deemed to have declined COBRA coverage.

When is my initial premium payment due?

Your full COBRA premium payments are due on the first of every month. COBRA laws allow for a 30-day grace period after the due date. If your full premium payments are not received by 30 days after the due date, your COBRA coverage will be cancelled retroactive to the first day of the month for which the full premium payment is due.

What if I fail to make subsequent required payments?

A COBRA premium payment (other than the initial premium payment) will be considered timely if made within 30 days after the premium's due date. A qualified beneficiary's COBRA coverage will terminate (without any ability to reinstate it) for failure to pay the required subsequent COBRA monthly payments on time. A cancellation notice will be sent to the qualified beneficiary if his or her full premium payment is not received.

Beyond Your Benefits

Legal Notices

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors', and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. As of January 2002, the maximum taxable annual wage for FICA is $84,900. There is no maximum taxable annual wage for Medicare. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. An Enrollment Representative can approximate any Social Security reduction during a Personal Enrollment Session or you can call FBMC Customer Service at 1-800-342-8017 for an approximation.

Processing Claims for Debit Card Transactions

All claims for eligible Flexible Spending Account expenses require supporting documentation in the form of receipts — including debit card transactions. If you are using your debit card, you have 30 days from the time you swipe your card to submit your supporting documentation or receipts. If you do not send in your receipts within 30 days, FBMC will notify you in writing that a transaction is outstanding and you must send the receipt(s) in order for that claim to be qualified and processed.

You have 20 days from the date you receive the first letter to comply with the request for outstanding receipts. If you do not submit a receipt within 20 days, your debit card will be suspended and you cannot use your card. After receipts for outstanding transactions are sent to FBMC, contact Customer Service at 1-800-342-8017 for information on restoring your debit card privileges.

Automatic Substitution for Debit Card Receipts

The IRS requires documentation of all Flexible Spending Account transactions. FBMC will continue notifying you in writing that documentation is needed/required to validate your debit card transactions (e.g. original receipts, substitute receipts, medical needs letter or payments, etc.).

FBMC will apply approved paper claim requests to any outstanding debit card transactions. After receiving and processing approved debit card receipts, a payment will be made to you representing the difference between the approved paper claim(s) and any outstanding debit card transactions (if applicable).

Example: A debit card participant, John, has not submitted receipts for three (3) debit card transactions, each in the amount of $10.00. Later, John submits a paper reimbursement request form for an eligible, out-of-pocket expense totaling $120.00 and the entire amount is authorized for reimbursement. John will receive a reimbursement payment of $90.00. The remaining $30.00 of the $120.00 reimbursement request will be used to offset the outstanding debit card transactions. After receiving and processing approved debit card receipts, a payment will be sent to John which represents the difference between the approved paper claim ($120.00) and the outstanding debit card transactions ($30.00).

Deferred Compensation

Participation in a Commonwealth Choice Flexible Spending Account may affect an employee's maximum contribution to the Kentucky Public Employee's 457 Deferred Compensation Plan (Plan I). Commonwealth Choice reduces the gross income from which the maximum deferrable amount is computed. Therefore, flexible benefit plan contributions should be reviewed carefully by employees who are now contributing the allowable maximum to the 457 deferred compensation plan. The Kentucky Public Employees' 401(k) Deferred Compensation Plan (Plan II) is not impacted by a Commonwealth Choice Flexible Spending Account.

The 2003 maximum allowable contribution for an employee contributing to Deferred Compensation Plan I (Internal Revenue Code, Section 457) is $11,000 or 100 percent of adjusted gross income, whichever is less. Adjusted gross is income remaining after reduction of employer "pick-up" of retirement contribution, health insurance premiums, flexible spending accounts, shelter plans, e.g., 457s, 401(k)s, 401(b)s.

If you have any questions and to ensure you are within the allowable maximum under the Internal Revenue Code guidelines, please call Deferred Comp at 1-800-542-2667 or 1-502-573-7925.

FBMC Privacy Notice

This notice applies to products administered by Fringe Benefits Management Company and its wholly-owned subsidiaries (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal—and sometimes, sensitive—information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This notice explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. FBMC's privacy policy is as follows:

I. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service, and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:
   - Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status, and spousal and beneficiary information.
   - Responses from you and others such as information relating to your employment and insurance coverage.
   - Information about your relationships with us, such as products and services purchased, transaction history, claims history, and premiums.
   - Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic, and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies, and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

III. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena, or to prevent fraud.

We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Notice of Administrator's Capacity

PLEASE READ: This notice advises flexible spending account participants of the identity and relationship between Commonwealth of Kentucky and its Contract Administrator, FBMC. FBMC is not an insurance company. FBMC has been authorized by your employer to provide administrative services for the flexible spending account plans offered herein. FBMC will process claims for reimbursement promptly. In the event there are delays in claims processing, you will have no greater rights in interest or other remedies against FBMC than would otherwise be afforded to you by law.

FBMC

Fringe Benefits Management Company

Contract Administrator
Fringe Benefits Management Company
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Customer Service 1-800-342-8017 • 1-800-955-8771 (TDD)
www.fbmc-benefits.com

Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.

FBMC/KY/0802